people powered health plans

Prior Authorization Criteria Updates Effective March 1, 2022

UCare Individual & Family Plans
UCare Individual & Family Plans with M Health Fairview

On March 1, 2022, prior authorization criteria for the drugs listed below will be updated. These changes will be reflected in the 2022 Prior Authorization Criteria document.

Actemra	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Polymyalgia Rheumatica.
Exclusion Criteria	Concurrent Use with a Biologic Disease-Modifying Antirheumatic Drug (DMARD) or Targeted Synthetic DMARD. Crohn's disease. COVID-19.
Required Medical Information	Diagnosis and other medications tried for the diagnosis provided
Age Restrictions	PJIA/SJIA - 2 years of age and older. All other conditions - 18 years of age and older.
Prescriber Restrictions	RA/PJIA/SJIA/PMR/GCA - Prescribed by or in consultation with a rheumatologist. ILD - Prescribed by or in consultation with a rheumatologist or a pulmonologist.
Coverage Duration	ILD - 1 yr. RA/GCA/PMR/PJIA/SJIA - 6 mo. Continuation - 1 yr.
Other Criteria	Giant Cell Arteritis (GCA) - approve if pt has tried one systemic corticosteroid (e.g. prednisone). Interstitial Lung Disease Associated with Systemic Sclerosis (ILD) - approve if pt has elevated acute phase reactants (C-reactive protein (CRP) greater than 6 mg/mL, erythrocyte sedimentation rate (ESR) greater than 28 mm/h, or platelet count greater than 330 x 109/L), forced vital capacity (FVC) is greater than 55% of the predicted value, and diagnosis is confirmed by high-resolution computed tomography. Polyarticular Juvenile Idiopathic Arthritis (PJIA) - approve if the patient will be starting on Actemra subcutaneous concurrently with methotrexate, sulfasalazine, or leflunomide (or has a contraindication) or has aggressive disease AND has tried Humira, Enbrel, an infliximab product, or Simponi Aria or the pt has heart failure or a previously treated lymphoproliferative disorder. Rheumatoid Arthritis (RA) - approve if the patient has tried Humira, Cimzia, Enbrel, an infliximab product, or Simponi OR the pt

	has heart failure or a previously treated lymphoproliferative disorder. Systemic Juvenile Idiopathic Arthritis (SJIA) - approve if the patient has tried ONE other systemic agent for this condition (e.g., a corticosteroid, a conventional synthetic DMARD, or a 1-month trial of an NSAID). Polymyalgia Rheumatica (PMR) - approve if the patient has tried one systemic corticosteroid (e.g., prednisone). Continuation - approve if pt has been established on therapy for at least the initial approval duration and pt experienced a beneficial clinical response from baseline when assessed by at least one objective measure or patient experienced an improvement in at least one symptom.

Cimzia	
PA Criteria	**Criteria Details**
Covered Uses	All FDA approved indications. Spondyloarthritis (SpA), Other subtypes.
Exclusion Criteria	Concurrent Use with a Biologic or with a Targeted Synthetic Disease-Modifying Antirheumatic Drug (DMARD).
Required Medical Information	diagnosis, medication history
Age Restrictions	CD/PP - 18 years and older
Prescriber Restrictions	AS/nr-axSpA/RA/SpA - prescribed by or in consultation with a rheumatologist. CD - prescribed by or in consultation with a gastroenterologist. PP - prescribed by or in consultation with a dermatologist. PsA - prescribed by or in consultation with a rheumatologist or a dermatologist.
Coverage Duration	AS/CD/nf-axSpA/PsA/RASpA - 6 mo. PP - 3 mo. Continuation - 1 yr.
Other Criteria	Ankylosing Spondylitis (AS) - approve if pt has tried two of Enbrel, Humira, and Taltz. Crohn's disease (CD) - approve if pt has tried Humira. Non-Radiographic Axial Spondyloarthritis (nr-axSpA) - approve if pt has C-reactive protein (CRP) elevated beyond the upper limit of normal OR sacroiliitis reported on magnetic resonance imaging (MRI). Plaque Psoriasis (PP) - approve if pt has tried two of Enbrel, Humira, Otezla, Skyrizi, Stelara subcutaneous, Taltz, and Tremfya. Psoriatic Arthritis (PsA) - approve if pt has tried two of Enbrel, Humira, Otezla, Stelara subcutaneous, Taltz, Tremfya, and Xeljanz/XR. Rheumatoid Arthritis (RA) - approve if pt has tried two of Actemra subcutaneous, Enbrel, Humira, Rinvoq, and Xeljanz/XR. Spondyloarthritis (SpA) - approve if pt has arthritis primarily in the knees, ankles, elbows, wrists, hands, and/or feet and has tried at least one conventional synthetic disease-modifying antirheumatic drug (DMARD). Continuation - approve if pt has been established on therapy for at least the initial approval duration and pt experienced a

	beneficial clinical response from baseline when assessed by at least one objective measure or patient experienced an improvement in at least one symptom.

Daurismo	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	
Required Medical Information	Diagnosis, other therapies
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Acute Myeloid Leukemia - Approve if the pt will be using the medication in combination with cytarabine.

Eligard	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	1 year
Other Criteria	Prostate Cancer - Approve. Head and Neck Cancer, Salivary Gland Tumors - Approve if pt has distant metastases and androgen receptor-positive disease.

Enbrel	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded plus Behcet's Disease, Graft-Versus-Host Disease, Pyoderma Gangrenosum, Spondylarthritis, and Still's Disease.
Exclusion Criteria	Concurrent Use with a Biologic DMARD or Targeted Synthetic DMARD. Crohn's disease. Inflammatory myopathies (polymyositis, dermatomyositis, inclusion body myositis). Hidradenitis Suppurativa. Polymyalgia Rheumatica. Large Vessel Vasculitis (Giant Cell Arteritis, Takayasu's Arteritis). Wegener's Granulomatosis.
Required Medical Information	Diagnosis and previous therapies tried
Age Restrictions	PP - 4 years or older
Prescriber Restrictions	Prescribed by or in consultation with: RA/AS/JIA/JRA/SpA/SD - rheumatologist. PP/PG - dermatologist. PsA - rheumatologist or dermatologist. Behcet's - rheumatologist, dermatologist, ophthalmologist, gastroenterologist, or neurologist. GVHD - oncologist, hematologist, or a physician in a transplant center.
Coverage Duration	AS/JIA/PsA/RA/SpA/SD - 6 mo. PP/BD -3mo GVHD-1mo PG-4mo. Cont GVHD - 3 mo. Cont all others - 1 yr
Other Criteria	Ankylosing Spondylitis (AS) - Approve. Juvenile Idopathic Arthritis (JIA) - Approve if pt has tried one other systemic agent for this condition, pt will be starting on Enbrel concurrently with methotrexate (MTX), sulfasalazine, or leflunomide, pt has an absolute contraindication to MTX, sulfasalazine, or leflunomide, or pt has aggressive disease, as determined by the prescribing physician. Plaque Psoriasis (PP) - Approve if pt has tried at least one traditional systemic agent for psoriasis or a biologic for at least 3 months, unless intolerant. Psoriatic Arthritis (PsA) - Approve. Rheumatoid Arthritis (RA) - Pt has tried ONE conventional synthetic disease-modifying antirheumatic drug (DMARD) or biologic for at least 3 months. Behcet's Disease (BD) - Approve if pt has tried at least one conventional therapy or biologic. Graft vs. Host Disease (GVHD) - Approve if pt has tried one conventional treatment. Pyoderma Gangrenosum (PG) - Approve if pt has tried one systemic corticosteroid or one other immunosuppressant for at least 2 months or was intolerant. Spondyloarthritis (SpA) - Approve if pt has arthritis primarily in the knees, ankles, elbows, wrists, hands, and/or feet AND has tried at least ONE conventional synthetic DMARD OR The patient has axial spondyloarthritis with objective measures of inflammation (elevated CRD, sacroiliitis on MRI). Still's Disease (SD) - Approve if pt has tried one corticosteroid and one conventional synthetic DMARD for at least 2 months or was intolerant. Continuation - approve if pt

	has been established on therapy for at least the initial approval duration and pt experienced a beneficial clinical response from baseline when assessed by at least one objective measure or patient experienced an improvement in at least one symptom.

Gonadotropin-Releasing Hormone Agonists - Injectable Long-Acting Products	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Abnormal Uterine Bleeding. Breast Cancer. Gender Dysphoric/Gender-Incongruent Persons, Persons Undergoing Gender Reassignment. Head and Neck Cancer – Salivary Gland Tumors. Ovarian Cancer. Preservation of Ovarian Function/Fertility in Patients Undergoing Chemotherapy. Prophylaxis or Treatment of Uterine Bleeding in Patients with Hematologic Malignancy, or Undergoing Cancer Treatment, or Prior to Bone Marrow/Stem Cell Transplantation (BMT/SCT).
Exclusion Criteria	Hirsutism. Menstrual Migraine. Premenstrual Syndrome (PMS). Polycystic Ovarian Syndrome (PCOS).
Required Medical Information	Diagnosis, concurrent medications
Age Restrictions	
Prescriber Restrictions	Cancer/Ovarian Function/Bleeding due to Cancer - prescribed by or in consultation with an oncologist. Gender - prescribed by or in consultation with an endocrinologist or a physician who specializes in the treatment of transgender patients.
Coverage Duration	Endometriosis/Cx/Ovarian/Bleeding Cx/Gender/CPP - 1 year. Leiomyomata - 3 mo. Uterine Bleeding - 6 months.
Other Criteria	Endometriosis - approve if pt has tried a contraceptive, an oral progesterone, or depo-medroxyprogesterone injection, unless contraindicated. Uterine Leiomyomata - approve. Prostate/Breast/Ovarian cancer - approve. Preservation of Ovarian Function/Fertility in Patients Undergoing Chemotherapy/Prophylaxis or Treatment of Uterine Bleeding in Patients with Hematologic Malignancy, or Undergoing Cancer Treatment, or Prior to Bone Marrow/Stem Cell Transplantation - approve. Abnormal Uterine Bleeding - approve. Head and Neck Cancer - Salivary Gland Tumors - approve if pt has advanced salivary gland tumors with distant metastases and androgen receptor (AR)-positive disease.

Humira	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded plus Behcet's Disease, Pyoderma Grangrenosum, Sarcoidosis, Scleritis (Sterile Conreal Ulceration), Spondyloarthritis.
Exclusion Criteria	Concurrent use with biologic DMARD or targeted synthetic DMARD (does not include methotrexate, hydroxychloroquine, sulfasalazine, and leflunomide). Polymyalgia rheumatica.
Required Medical Information	Diagnosis and previous medications tried
Age Restrictions	CD - 6 years or older. PP - 18 years or older. UC - 5 years or older
Prescriber Restrictions	RA/JIA/JRA/AS/SpA - rheumatologist. PsA - rheumatologist or dermatologist. PP/PG/HS - dermatologist. UC/CD - gastroenterologist. Uveitis/Scleritis - ophthalmologist. Sarcoidosis - pulmonologist, ophthalmologist, or dermatologist. Bechet's - rheumatologist, dermatologist, ophthalmologist, gastroenterologist, or neurologist.
Coverage Duration	AS/CD/PsA/UC/UV/Bechet's/Scleritis - 6 months. PG - 4 mos. HS/PP/Sarcoidosis - 3 mo. Continuation - 1 yr.
Other Criteria	Ankylosing Spondylitis (AS) - Approve. Crohn's Disease (CD) - Approve if the pt has tried corticosteroids (CS), CS are contraindicated, the pt has tried one other conventional systemic therapy for Crohn's disease, the pt has enterocutaneous (perianal or abdominal) or rectovaginal fistulas, or the pt has had ileocolonic resection. Juvenile Idiopathic Arthritis (JIA)- Approve if pt has tried one other systemic therapy for this condition, will be starting on adalimumab concurrently with methotrexate (MTX) sulfasalazine or leflunomide, pt has absolute contraindication to MTX sulfasalazine or leflunomide, or pt has aggressive disease. Hidradenitis Suppurativa (HS) - Approve if pt has tried at least one other therapy. Plaque Psoriasis (PP)- Approve if pt has tried at least one systemic therapy for at least 3 months, unless intolerant, the patient has tried at least one biologic for at least 3 months, or the patient has a contraindication to MTX as determined by the prescriber. Psoriatic Arthritis (PsA) - Approve. Rheumatoid Arthritis (RA) - Approve if pt has tried one conventional DMARD for at least 3 months or the patient has tried one biologic for at least 3 months. Ulcerative Colitis (UC) - Approve if pt has tried one systemic agent or one biologic agent, or the patient has pouchitis and has tried therapy with an antibiotic, probiotic, corticosteroid enema, or mesalamine enema. Uveitis (UV)- Approve if pt has tried one of the following therapies: periocular, intraocular, or systemic corticosteroids, immunosuppressives, or a biologic. Bechet's- Approve if pt has tried at least one conventional therapy or pt has ophthalmic manifestations of Behcet's disease.

	Pyoderma Gangrenosum (PG)- Approve if pt has tried one systemic corticosteroid or has tried one other immunosuppressant for at least 2 months or was intolerant to one of these agents. Sarcoidosis - Approve if pt has tried at least 1 corticosteroid and at least one immunosuppressive agent. Scleritis- approve if pt has tried one other therapy for this condition. Spondyloarthritis, Other (SpA)- Approve if pt has arthritis primarily in the knees, ankles, elbows, wrists, hands, and/or feet and has tried at least 1 conventional DMARD Or pt has axial spondyloarthritis and has objective signs of inflammation (elevated CRP, sacroiliitis on MRI). Continuation - approve if pt has been established on therapy for at least the initial approval duration and pt experienced a beneficial clinical response from baseline when assessed by at least one objective measure or patient experienced an improvement in at least one symptom.

Iron Chelators	
PA Criteria	**Criteria Details**
Covered Uses	All FDA approved indications not otherwise excluded. Deferiprone only: Iron Overload, Chronic – Non-Transfusion-Dependent Thalassemia Syndromes.
Exclusion Criteria	
Required Medical Information	diagnosis, serum ferritin level
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a hematologist
Coverage Duration	1 year
Other Criteria	Iron Overload, Chronic – Non-Transfusion-Dependent Thalassemia Syndromes - Approve if prior to starting chelating therapy, serum ferritin level was greater than 300 micrograms/liter. Continuation - Approve if the patient is benefiting from therapy, as confirmed by the prescriber. Iron Overload, Chronic – Transfusion-Related Due to Thalassemia Syndromes, Sickle Cell Disease, or Other Anemias (deferiprone only) - Approve if prior to starting chelating therapy, serum ferritin level was greater than 1,000 micrograms/liter. Continuation - Approve if the patient is benefiting from therapy, as confirmed by the prescriber. Iron Overload, Chronic – Transfusion-Related (deferasirox only) - Approve if pt is receiving blood transfusions at regular intervals for a chronic condition and prior to starting chelating therapy, serum ferritin level was greater than 1,000 micrograms/liter (mcg/L). Continuation - Approve if the patient is benefiting from therapy, as confirmed by the prescriber.

Lemtrada	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	Clinically Isolated Syndrome. Concurrent use with other Disease-Modifying Agents used for Multiple Sclerosis. Human Immunodeficiency Virus (HIV) Infection. Non-Relapsing Forms of Multiple Sclerosis.
Required Medical Information	Diagnosis, other therapies tried
Age Restrictions	17 years or older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or a physician who specializes in the treatment of multiple sclerosis
Coverage Duration	Initial - 5 doses. Continuation - 3 doses.
Other Criteria	Multiple Sclerosis - Initial - Approve if pt has a relapsing form of multiple sclerosis AND either has experienced inadequate efficacy or significant intolerance to two disease-modifying agents used for multiple sclerosis OR has highly-active or aggressive multiple sclerosis as defined by meeting one of the following: rapidly advancing deterioration(s) in physical functioning [documentation required], disabling relapse(s) with suboptimal response to systemic corticosteroids [documentation required], magnetic resonance imaging (MRI) findings suggest highly-active or aggressive multiple sclerosis [documentation required], or manifestations of multiple sclerosis-related cognitive impairment [documentation required]. Continuation - Approve if pt has a relapsing form of multiple sclerosis and at least 12 months has elapsed from the last dose of any prior Lemtrada treatment course.

Otezla	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	Concurrent use with a biologic DMARD or targeted synthetic DMARD. Ankylosing spondylitis. Rheumatoid arthritis.
Required Medical	Diagnosis, previous medications tried

Information	
Age Restrictions	18 years and older
Prescriber Restrictions	Behcet's/PsA - prescribed by or in consultation with a rheumatologist or a dermatologist. PP - prescribed by or in consultation with a dermatologist.
Coverage Duration	Bechet's/PP - 4 months. PsA - 6 months. Continuation - 1 year.
Other Criteria	Behcet's - Approve if pt has oral ulcers or other mucocutaneous involvement and has tried at least one systemic therapy. Plaque Psoriasis (PP) - Approve if patient has tried at least one traditional systemic agent for psoriasis for at least 3 months, unless intolerant or the pt has a contraindication to MTX, as determined by the prescribing physician. Psoriatic Arthritis (PsA)- Approve. Continuation - approve if pt has been established on therapy for at least the initial approval duration and pt experienced a beneficial clinical response from baseline when assessed by at least one objective measure or patient experienced an improvement in at least one symptom.

Revcovi	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	
Required Medical Information	Diagnosis, baseline labs or genetic testing results
Age Restrictions	
Prescriber Restrictions	prescribed by or in consultation with an immunologist, hematologist/oncologist, or physician that specializes in ADA-SCID or related disorders
Coverage Duration	1 year
Other Criteria	Adenosine Deaminase Severe Combined Immunodeficiency (ADA-SCID) - Approve if pt has a diagnosis of ADA-SCID confirmed by molecular genetic testing confirming bi-allelic mutations in the ADA gene or at baseline (i.e., prior to initiating enzyme replacement therapy), the patient has had absent or very low (less than 1% of normal) adenosine deaminase (ADA) catalytic activity.

Rinvoq	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	Concurrent use with a biologic or with a targeted synthetic DMARD. Concurrent use with other potent immunosuppressants. COVID-19.
Required Medical Information	Diagnosis, previous therapies tried
Age Restrictions	18 years and older
Prescriber Restrictions	PsA - Prescribed by or in consultation with a rheumatologist or dermatologist. RA - Prescribed by or in consultation with a rheumatologist.
Coverage Duration	Initial - 6 months. Continuation - 1 year.
Other Criteria	Psoriatic Arthritis (PsA) - Approve if pt has tried at least one tumor necrosis factor inhibitor for at least 3 months, unless intolerant. Rheumatoid Arthritis (RA) - Approve if pt has tried at least one tumor necrosis factor inhibitor for at least 3 months, unless intolerant. Continuation - Approve if pt has been established on therapy for at least the initial approval duration and pt experienced a beneficial clinical response from baseline when assessed by at least one objective measure or patient experienced an improvement in at least one symptom.

Skyrizi	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded from coverage.
Exclusion Criteria	Concurrent Use with other Biologics or Targeted Synthetic Disease-Modifying Antirheumatic Drugs (DMARDs)
Required Medical Information	Diagnosis, Previous medication use
Age Restrictions	18 years of age and older
Prescriber Restrictions	PP- Prescribed by or in consultation with a dermatologist
Coverage Duration	Initial therapy - 3 months, Continuation therapy - 1 years
Other Criteria	Plaque Psoriasis - Approve if pt has tried at least one traditional

	systemic agent or a biologic for at least 3 months, unless intolerant or has a contraindication to MTX as determined by prescriber. Continuation - approve if pt has been established on therapy for at least the initial approval duration and pt experienced a beneficial clinical response from baseline when assessed by at least one objective measure or patient experienced an improvement in at least one symptom.

Stelara	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	Concurrent use of another biologic or targeted synthetic DMARD. Ankylosing Spondylitis.
Required Medical Information	Diagnosis, previous therapies tried.
Age Restrictions	PP- 6 years or older. All other indications - 18 years or older.
Prescriber Restrictions	PP - prescribed by or in consultation with a dermatologist. PsA - prescribed by or in consultation with a rheumatologist or dermatologist. CD/UC - prescribed by or in consultation with a gastroenterologist.
Coverage Duration	CD/PsA/UC - 6 months. PP - 3 months. Continuation - 1 year.
Other Criteria	Crohn's Disease (CD) - Approve if pt has received a single induction dose with Stelara IV within 2 months of initiating therapy with Stelara SC and meets one of the following: pt has tried or is currently taking corticosteroids or corticosteroids are contraindicated, the pt has tried one conventional systemic therapy for Crohns disease, pt has already tried a biologic, pt has enterocutaneous (perianal or abdominal) or rectovaginal fistulas, or pt had ileocolonic resection (to reduce the chance of Crohn's disease recurrence). Plaque Psoriasis (PP) - Approve if pt has tried at least at least one traditional systemic agent for psoriasis for at least 3 months unless intolerant, the pt has already tried a biologic for 3 months, or the pt has a contraindication to methotrexate, as determined by the prescribing physician. Psoriatic Arthritis (PsA) - Approve. Ulcerative Colitis (UC) - Approve if pt has had a trial of one systemic agent for UC and will receive a single induction dose with Stelara IV within 2 months of initiating therapy with Stelara SC. Continuation - approve if pt has been established on therapy for at least the initial approval duration and pt experienced a beneficial clinical response from baseline when assessed by at least one objective measure or patient experienced an improvement in at

	least one symptom.

Taltz	
PA Criteria	**Criteria Details**
Covered Uses	All FDA approved indications not otherwise excluded.
Exclusion Criteria	Concurrent use of biologic or targeted synthetic DMARDS. Inflammatory bowel disease (Crohn's, ulcerative colitis).
Required Medical Information	Diagnosis and previous therapies tried
Age Restrictions	PP- 6 years or older.
Prescriber Restrictions	AS/NRAS - prescribed by or in consultation with a rheumatologist. PP- prescribed by or in consultation with a dermatologist. PsA- prescribed by or in consultation with a rheumatologist or dermatologist.
Coverage Duration	AS/NRAS/PsA - 6 months. PP - 3 months. Continuation - 1 year
Other Criteria	Ankylosis Spondylitis (AS) - Approve. Non-Radiographic Axial Spondyloarthritis (NRAS) - Approve if pt has objective signs of inflammation (elevated CRP, sacroiliitis on MRI). Plaque Psoriasis (PP) - Approve if pt has tried at least one traditional systemic agent for psoriasis for at least 3 months, unless intolerant OR the pt has a contraindication to methotrexate, as determined by prescriber. Psoriatic Arthritis (PsA) - Approve. Continuation - approve if pt has been established on therapy for at least the initial approval duration and pt experienced a beneficial clinical response from baseline when assessed by at least one objective measure or patient experienced an improvement in at least one symptom.

Trelstar	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber	Prescribed by or in consultation with an oncologist.

Restrictions	
Coverage Duration	1 year
Other Criteria	Advanced Prostate Cancer - Approve.

Tremfya	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded from coverage.
Exclusion Criteria	Concurrent Use with other Biologics or Targeted Synthetic Disease-Modifying Antirheumatic Drugs (DMARDs)
Required Medical Information	Diagnosis, Previous medication use
Age Restrictions	PP - 18 years of age and older
Prescriber Restrictions	PP- Prescribed by or in consultation with a dermatologist. PsA - Prescribed by or in consultation with a rheumatologist or dermatologist.
Coverage Duration	PP - 3 months. PsA - 6 months. Continuation - 1 year
Other Criteria	Plaque Psoriasis (PP) - Approve if patient has tried at least one traditional or biologic systemic agent for psoriasis for at least 3 months unless intolerant, or the patient has a contraindication to methotrexate , as determined by the prescriber. Psoriatic Arthritis (PsA) - Approve. Continuation - approve if pt has been established on therapy for at least the initial approval duration and pt experienced a beneficial clinical response from baseline when assessed by at least one objective measure or patient experienced an improvement in at least one symptom.

Triptodur	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Gender-Dysphoric/Gender-Incongruent Persons, Persons Undergoing Gender Reassignment (Female-To-Male or Male-To-Female).
Exclusion Criteria	
Required Medical Information	Diagnosis

Age Restrictions	
Prescriber Restrictions	Gender dysphoria - Prescribed by or in consultation with an endocrinologist or a physician who specializes in the treatment of transgender patients.
Coverage Duration	1 year
Other Criteria	Central Precocious Puberty - Approve. Gender-Dysphoric/Gender-Incongruent Persons, Persons Undergoing Gender Reassignment (Female-To-Male or Male-To-Female) - Approve.

Xeljanz	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	Concurrent use with Biologic or Targeted Synthetic DMARDs. Concurrent use with other potent immunosuppressants (azathioprine, tacrolimus, cyclosporine, mycophenolate). COVID-19. Renal Transplantation.
Required Medical Information	Diagnosis, other therapies tried
Age Restrictions	AS/PsA/RA/UC - 18 years or older
Prescriber Restrictions	AS/RA/JIA-prescribed by or in consultation with a rheumatologist. PsA-prescribed by or in consultation with a dermatologist or rheumatologist. UC-prescribed by or in consultation with a gastroenterologist.
Coverage Duration	AS/RA/JIA/JRA/PsA/UC - 6 months. Continuation - 1 yr.
Other Criteria	Ankylosing Spondylitis (AS) - Approve if pt has tried at least one tumor necrosis factor inhibitor for at least 3 months, unless intolerant. Juvenile Idiopathic Arthritis (JIA) - Approve if pt has tried at least one tumor necrosis factor inhibitor for at least 3 months, unless intolerant. Psoriatic Arthritis (PSA) - Approve if patient has tried at least one tumor necrosis factor inhibitor for at least 3 months, unless intolerant, and the medication will be used in combination with methotrexate or another conventional synthetic disease-modifying antirheumatic drug (DMARD), unless contraindicated. Rheumatoid Arthritis (RA) - Approve if pt has tried at least one tumor necrosis factor inhibitor for at least 3 months, unless intolerant. Ulcerative Colitis (UC) - Approve if pt has tried at least one tumor necrosis factor inhibitor for at least 3 months, unless intolerant. Continuation - Approve if pt has been established on therapy for at least the initial approval duration and pt

	experienced a beneficial clinical response from baseline when assessed by at least one objective measure or patient experienced an improvement in at least one symptom.

Xospata	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Myeloid/Lymphoid Neoplasms.
Exclusion Criteria	
Required Medical Information	Diagnosis, mutation results
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Acute Myeloid Leukemia - Approve if pt has relapsed or refractory disease and disease is FLT3-mutation positive. Myeloid/Lymphoid Neoplasms - Approve if pt has eosinophilia and disease is FLT3-mutation positive.

Zejula	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Uterine Leiomyosarcoma.
Exclusion Criteria	
Required Medical Information	Diagnosis, previous therapies tried, mutation results
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Ovarian, Fallopian Tube, or Primary Peritoneal Cancer (Maintenance) - Approve if pt has had a complete or partial response after a platinum-based chemotherapy regimen. Ovarian, Fallopian Tube, or Primary

	Peritoneal Cancer (Treatment) - Approve if pt has tried at least 3 prior chemotherapy regimens and has homologous recombination deficiency (HRD)-positive disease. [Note: HRD-positive disease includes patients with BRCA mutation-positive disease.] Uterine Leiomyosarcoma - Approve if pt has tried one systemic regimen and has a BRCA2 mutation.

Zytiga	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Prostate Cancer - Regional Risk Group. Prostate Cancer - Very-High Risk Group
Exclusion Criteria	
Required Medical Information	Diagnosis, other therapies used in combination
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	PC-VHRG - 2 years. All others - 3 years.
Other Criteria	Prostate Cancer – Metastatic, Castration-Resistant (mCRPC) - Approve if the medication is used in combination with prednisone or dexamethasone AND pt meets one of the following criteria: The medication is concurrently used with a gonadotropin-releasing hormone (GnRH) analog (e.g. Lupron, Lupron Depot, Trelstar, Zoladex), the medication is used concurrently with Firmagon, or pt has had a bilateral orchiectomy. Prostate Cancer –Metastatic, Castration-Sensitive (mCSPC) - Approve if the medication is used in combination with prednisone AND pt meets one of the following criteria: The medication is concurrently used with a GnRH analog, the medication is used concurrently with Firmagon, or pt has had a bilateral orchiectomy. Prostate Cancer – Regional Risk Group - Approve if the medication is used in combination with prednisone, pt has regional lymph node metastases and no distant metastases, and pt meets one of the following criteria: The medication is concurrently used with a GnRH analog, the medication is used concurrently with Firmagon, or pt has had a bilateral orchiectomy. Prostate Cancer - Very-High Risk Group (PC-VHRG) - Approve if pt is in the very-high-risk group, the medication is used in combination with external beam radiation therapy, and pt meets one of the

	following criteria: The medication is concurrently used with a GnRH analog, the medication is used concurrently with Firmagon, or pt has had a bilateral orchiectomy.